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# TO BE OR NOT TO BE, SHOULD DOCTORS DECIDE? ETHICAL AND LEGAL ASPECTS OF MEDICAL FUTILITY POLICIES

Maureen Kwiecinski\*

In 2005, Spiro Nikolouzos was a retired electrical engineer with significant and serious disabilities whose wife and family cared for him at home.<sup>1</sup> After Mr. Nikolouzos developed problems with his feeding tube, his family sought treatment at a local hospital.<sup>2</sup> Unfortunately, Mr. Nikolouzos' condition deteriorated in the hospital, and he was placed on a ventilator.<sup>3</sup> After some time, the health care providers treating Mr. Nikolouzos concluded that life-sustaining treatment was not his best interests and recommended that Mr. Nikolouzos' ventilator be disconnected and his feeding tube withdrawn.<sup>4</sup> However, the Nikolouzos family rejected this conclusion and strongly objected to the removal of life support, stating that withdrawal would be contrary to Mr. Nikolouzos' express wishes regarding his

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1. Spiro Nikolouzos had been in a persistent vegetative state since 2001. Todd Ackerman, *Life Support Removal Blocked: Appellate Court Grants Temporary Injunction to the Family of Man at St. Luke's Hospital*, HOUSTON CHRON. (Texas), Mar. 13, 2005, at B6 [hereinafter *Life Support Removal*]. The cause of Mr. Nikolouzos' initial condition is somewhat uncertain.

2. See *id.*

3. See *id.*

4. See Todd Ackerman, *Burden of Proof Lies With Kin of Patient; Family of Man on Life Support at St. Luke's Must Show He Can Be Taken Elsewhere*, HOUSTON CHRON. (Texas), Mar. 19, 2005, at B1 [hereinafter *Burden of Proof*].

medical care.<sup>5</sup>

Despite the Nikolouzos family's objections and their contention that withdrawal would be inconsistent with Mr. Nikolouzos' personal preferences, health care providers remained convinced that removing life-support would be in Mr. Nikolouzos' best interests. The hospital notified Mrs. Nikolouzos that unless she could find a facility that would assume the care of her husband, life-sustaining treatment would be withdrawn in ten days.<sup>6</sup> After the Nikolouzos family's frantic search for a transfer facility failed, the hospital prepared for the removal of treatment and started an intravenous morphine drip. However, a last minute appeal to the court resulted in an emergency injunction barring the removal of treatment, and shortly thereafter Mr. Nikolouzos was transferred to another facility. After the transfer, the Nikolouzos family, suspicious that the hospital sought to remove treatment for financial reasons, expressed considerable bitterness towards the hospital and health care providers.<sup>7</sup>

Disagreements between family members and health care providers over the withholding and withdrawal of life-sustaining medical treatment are not a new phenomenon. In the 1970's and 1980's, courts considered a number of unresolved provider-family disagreements, most of which centered on the following question: What should be done when a patient or his surrogate refuses or seeks to discontinue life-sustaining medical

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5. See Nicole Foy, *Texas Law Gives Hospitals Right to End Life Support: It Seeks to Balance Views of Physicians and Feelings of Families*, SAN ANTONIO EXPRESS-NEWS (Texas), Mar. 27, 2005, at 1A. (Mr. Nikolouzos' son asserted that the family understood Spiro would not recover, but that the decision to withdraw life-support should be made by the family, not the hospital); In addition, the Nikolouzos family suspected that the effort to remove life-support was triggered by the depletion of Mr. Nikolouzos' Medicare funding. The Nikolouzos family also maintained that the hospital was being "pushy" and trying to force the family into withdrawing support, even though it was not consistent with Spiro's wishes. See Leigh Hopper, *Hospitals Can End Life Support; Decision Hinges on Patient's Ability to Pay, Prognosis*, HOUSTON CHRON. (Texas), Mar. 8 (2005), at B6 (reporting that the chief medical officer of a local hospital stated "[a] patient's inability to pay for medical care combined with a prognosis that renders further care futile are two reasons a hospital might suggest cutting off life support").

6. See Ackerman, *Life Support Removal*, *supra* note 1.

7. See Hopper, *supra* note 5.

treatment, but health care providers favor more aggressive care? This question, and other end-of-life treatment disputes, brought physicians, patients, and family members to courthouses across the nation, resulting in several United States Supreme Court decisions and a myriad of appellate and lower court opinions. Recently, however, the focus of debate has shifted to an opposing question: What should be done when health care providers contend that a life-sustaining medical intervention, such as ventilatory support, dialysis, or artificial feeding, should be withheld or withdrawn but the patient or family members disagree?

Futility policy supporters claim that health care providers, as a consequence of their expertise and training, are best able to determine when continuing medical treatment is no longer worthwhile. As a result of this argument, if health care providers decide that a treatment lacks benefit, and is therefore "futile," providers should have the discretion to withhold or withdraw even life-sustaining interventions without the consent of the patient or family members.<sup>8</sup> Futility policy critics contend that decisions regarding the benefits and burdens of life-sustaining treatment are inherently subjective and value-laden determinations; since health care providers, have limited knowledge of their patients' preferences and may be improperly influenced by bias, prejudice, or institutional pressures, they are ill-equipped to render accurate and objective decisions. Therefore, when a disagreement about life-sustaining medical treatment arises, the goals of the patient, as described by the patient or his or her family, should guide decision-making.<sup>9</sup>

Despite these differences in opinion, in the mid to late 1990's, professional organizations and policy supporters advocated for the development of institutional "futility policies"

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8. See Susan Rubin, *WHEN DOCTORS SAY NO: THE BATTLEGROUND OF MEDICAL FUTILITY* 56-57 (Indiana University Press 1998).

9. See, e.g., Michael Ardagh, *Futility Has No Utility in Resuscitation Medicine*, 26 J. MED. ETHICS 396, 396 (Oct. 2000); Leigh Turner, *Recognizing the Persistence of an Ethical Conflict: Disputes Concerning What Constitutes Appropriate Levels of Care: Part I*, 18 ANNALS LONG TERM CARE 15, 18 (2004).

to address provider-family conflicts concerning "futile" or "medically inappropriate" treatment.<sup>10</sup> While the content of these policies varies considerably, some policies provide that a physician who determines that a treatment is "futile" or "inappropriate" can withhold or withdraw the treatment without the consent of the patient or a surrogate decision-maker.<sup>11</sup> In 1999, the Texas legislature took the unprecedented step of codifying a futility policy, creating a legislatively approved, largely extrajudicial process that allows physicians to remove life-sustaining treatment without the consent of the patient or family members.<sup>12</sup>

The development and implementation of futility policies is not without controversy and many have questioned whether policies that allow health care providers to act unilaterally are ethically and legally acceptable. Despite the support of various professional organizations, commentators and practitioners continue to ask: Are health care providers' opinions regarding a treatment's "futility" sufficient to ethically justify a unilateral decision to withdraw life-sustaining treatment? And, even if a unilateral decision can be supported ethically, do the processes set forth in futility policies, whether statutory or institutional, adequately protect the due process rights of individuals, and the vital interests of vulnerable populations, such as the elderly or the disabled?

This comment discusses both of these questions. Part I of this article provides background on the withholding and withdrawal of life-sustaining treatment and the conflicts that

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10. See, e.g., Council on Ethical and Judicial Affairs, American Medical Association, *Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs*, 281 JAMA 937, 940 (1999) (stating, "[t]he Council... recommends that health care institutions, whether large or small, adopt a policy on medical futility. . ."). Amir Halevy & Baruch Brody, *A Multi-Institution Collaborative Policy on Medical Futility*, 276 JAMA 571, 574 (1996); David Waisel & Robert Truog, *The Cardiopulmonary Resuscitation-Not-Indicated Order: Futility Revisited*, 122 ANNALS INTERN. MED. 304, 306-308 (1995) (discussion of four different hospital policies); Sandra Johnson et al., *Legal and Institutional Policy Responses to Medical Futility*, 30 J. HEALTH L. 21, 34 (1997).

11. See Johnson et al., *supra* note 10, at 27; TEX. HEALTH & SAFETY CODE ANN. §§ 166.045-166.052 (Westlaw through 2004 legislation).

12. See *id.*

arise between providers and family members. Part II discusses the concept of medical futility and reviews ethical justifications and criticisms for the unilateral withholding or withdrawal of treatment based upon medical futility. Part III explores the legal implications of institutional and statutory futility policies, focusing on the Texas Advance Directives Act. This section concludes that institutional and statutory futility policies, which allow health care providers to override the treatment preferences of a competent patient or surrogate decision maker, violate the common law principle of self-determination and constitutional guarantees of procedural due process. Part IV concludes that substantial unanswered ethical and legal questions arise when physicians attempt to unilaterally withhold or withdraw life-sustaining treatment from incompetent patients pursuant to institutional or statutory medical futility policies. Because such policies concern vital and very personal decisions, the ethical and legal issues surrounding these policies should be a matter of active, informed public debate.

## **I. BACKGROUND INFORMATION ON THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING MEDICAL TREATMENTS**

The withholding or withdrawal of life support is a process through which medical interventions, such as ventilators and feeding tubes,<sup>13</sup> are either not implemented or are removed from patients with the expectation that the patient's death will occur as a result of an underlying condition.<sup>14</sup> Studies demonstrate that in many countries, between seventy and ninety percent of

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13. See David Asch et al., *Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes*, 151 AM. J. RESPIRATORY & CRITICAL CARE MED. 288, 290 (1995) (Life sustaining medical interventions may also include cardiac defibrillation, blood pressure medications, surgery, insulin, antibiotics, dialysis, intravenous fluids, and blood/blood product transfusions.).

14. See John Luce & Ann Alpers, *Legal Aspects of Withholding and Withdrawing Life Support from Critically Ill Patients in the United States and Providing Palliative Care to Them*, 162 AM. J. RESPIR. CRIT. CARE MED. 2029, 2029 (2000).

deaths that occur in intensive care units (ICUs) are preceded by a decision to withhold or withdraw life-sustaining treatments.<sup>15</sup> In the United States, this percentage has increased significantly over a relatively short period of time, rising from fifty percent of ICU patient deaths in 1987-88, to over ninety percent in 1993.<sup>16</sup>

While the increased percentage of deaths as a result of withholding or withdrawal seems to suggest a high level of consistency in end-of-life treatment practices, caregivers make a wide variety of end-of-life recommendations.<sup>17</sup> Research demonstrates that even among groups of patients who receive end-of-life treatment at well-respected medical centers, there are "striking" inter-hospital and regional differences in end-of-life care.<sup>18</sup> At least one team of researchers concluded that these variations in practice indicate a lack of consistent guidelines for

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15. See T.J. Prendergast & J.M. Luce, *Increasing Incidence of Withholding and Withdrawal of Life Support From the Critically Ill*, 155 AM. J. RESPIR. CRIT. CARE MED. 15 (1997) (abstract); see also Sean Keenan et al., *A Retrospective Review of a Large Cohort of Patients Undergoing the Process of Withholding or Withdrawal of Life Support*, 25 CRIT. CARE MED. 1324, 1324 (1997) (confirming the high rate of withholding or withdrawal of life-sustaining treatment among patients dying in academic ICUs); Eduoard Ferrand et al., *Withholding and Withdrawal of Life Support in Intensive Care Units in France: A Prospective Study*, 357 LANCET 9, 11 (2001); Johanna Groenewoud et al., *A Nationwide Study of Decisions to Forego Life-Prolonging Treatment in Dutch Medical Practice*, 160 ARCHIVES INTERNAL MED. 357, 357 (2000).

16. See Prendergast & Luce, *supra* note 15, at 15.

17. See Thomas Prendergast et al., *A National Survey of End-of-life Care for Critically Ill Patients*, 158 AM. J. RESPIR. CRIT. CARE MED. 1163, 1164 (1998); Robert M. Wachter et al., *Decisions About Resuscitation: Inequities Among Patients with Different Diseases But Similar Prognoses*, 111 ANNALS INTERNAL MED. 525, 525 (1989) (noting that in a survey of physicians, despite similar prognoses, patients with AIDS or lung cancer were more likely to get Do-Not-Resuscitate orders than patients with cirrhosis or severe congestive heart failure.); Deborah Cook et al., *Determinations in Canadian Health Care Workers of the Decision to Withdraw Life Support From the Critically Ill*, 273 JAMA 703, 703 (1995) (reporting that in a study in which hypothetical scenarios involving critically ill adults were presented to over one thousand ICU physicians and nurses, the majority of respondents agreed on course of treatment in only 8% of cases.).

18. See John Wennberg et al., *Use of Hospitals, Physician Visits and Hospice Care During Last Six Months of Life Among Cohorts Loyal to Highly Respected Hospitals in the United States*, 328 BRITISH MED. J. 1 (2004) (reporting the following ranges: days in hospital per decedent (9.4 to 27.1), days in intensive care (1.6 to 9.5), number of physician visits (17.6 to 76.2), percentage of patients seeing 10 or more physicians (16.9% to 58.5%), hospice enrolment (10.8% to 43.8%), percentage of deaths occurring in hospital ranged (15.9% to 55.6%), percentage of deaths associated with a stay in intensive care (8.4% to 36.8%).) available at <http://bmj.bmjournals.com/cgi/reprint/328/7440/607> (last visited February 27, 2005).

end-of-life medical treatment.<sup>19</sup>

The lack of consistent practice may be attributed in part to the wide variety of clinical factors that health care providers must consider when formulating end-of-life treatment recommendations for an individual patient.<sup>20</sup> However, research demonstrates that differences in treatment recommendations may also be associated with a number of non-clinical factors, including physicians' race and gender,<sup>21</sup> rank and experience,<sup>22</sup> specialty,<sup>23</sup> risk aversion,<sup>24</sup> religious convictions,<sup>25</sup>

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19. See Prendergast et al., *supra* note 17, at 1166.

20. See, e.g., Nicholas Smedira et al., *Withholding and Withdrawal of Life Support From the Critically Ill*, 322 NEW ENG. J. MED. 309, 312 (1990) (identifying poor prognosis, futility of continued intervention, extreme suffering, and patient or family request as reasons cited by physicians who recommended withholding or withdrawal of support.) Physicians may also consider potential professional malpractice liability and existing institutional standards. See Henry Perkins et al., *Impact of Legal Liability, Family Wishes, and Other 'External Factors' on Physician's Life-Support Decisions*, 89 AM. J. MED. 185, 185 (1990) (concluding that the potential for legal liability is an especially important factor when patient preferences are unknown). However, it appears the most commonly cited reason for recommending the withholding or withdrawal of life-sustaining treatment is the opinion that the patient's potential quality of life is poor. Asch et al., *supra* note 13, at 291; Keenan et al., *supra* note 15, at 1327 (reporting the most common reason given for the withdrawal of life support was poor patient prognosis (documented in 97% of cases). The next two most commonly considered reasons were: concern with regard to patient suffering (18%), and poor future quality of life (9%)). Accordingly, at least one commentator contends that regardless of an explicit futility policy, some conception of medical futility underlies the majority of withholding and withdrawal decisions.

21. See Eric Mebane et al., *The Influence of Physician Race, Age, and Gender on Physician Attitudes Toward Advance Care Directives and Preferences for End-Of-Life Decision-Making*, 47(5) J. AM. GERIATR. SOC. 579, 579 (1999) (describing significant differences in attitudes about tube feeding between white and black physicians, and male and female physicians. While 58% percent of white physicians agreed that tube-feeding in terminally ill patients is a "heroic" treatment, only 28% of black physicians agreed. While 42.4% of male physicians agreed that tube-feeding is "heroic," only 28.9% of female physicians agreed.); *Id.* at 583.

22. See Asch et al., *supra* note 13, at 291 (reporting that in a survey of end-of-life decision-making, younger physicians were more likely than older physicians to report withdrawing ventilator support); Panagiotis Caralis & Jamey Hammond, *Attitudes of Medical Students, Housestaff, and Faculty Physicians Toward Euthanasia and Termination of Life-sustaining Treatment*, 20 CRIT. CARE MED. 683, 683 (May 1992) (finding that faculty physicians rated disease-based information as strongly determinative of their end-of-life treatment decisions, while students and housestaff relied more heavily on quality-of-life factors); Nicholas Christakis & David Asch, *Physician Characteristics Associated with Decisions to Withdraw Life Support*, 85 AM. J. PUB. HEALTH 367, 367 (Mar. 1995) (reporting that physicians' personal characteristics, such as age and experience, were associated with differences in treatment preferences and practices with regard to the withdrawal of life support); Jeffery Rubenstein et al., *Pediatric Resident Attitudes About Technologic Support of Vegetative Patients and the Effects of Parental Input—A*



marital status,<sup>26</sup> and other factors.<sup>27</sup>

The lack of consensus on best practices at end-of-life is reflected in the significant incidence of inter-staff conflict when health care providers consider the withholding or withdrawal of life-sustaining treatments.<sup>28</sup> In one study of ICU patients for whom the withdrawal of life-sustaining treatment was proposed, disagreements among providers occurred in almost half the cases.<sup>29</sup> Not surprisingly, these providers also differ significantly in their opinions of how satisfactory they find the

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*Longitudinal Study*, 94 PEDIATRICS 8, 10 (Jul. 1994) (noting that the attitudes of pediatric residents with regard to the withdrawal of treatment from terminally ill children change over time).

23. See Laura Hanson et al., *Who Decides? Physicians' Willingness to Use Life-Sustaining Treatment*, 156 ARCHIVES INTERN. MED. 785, 785 (1996); William F. Kelly, *Do Specialists Differ on Do-Not-Resuscitate Decisions?* 121 CHEST 957, 957 (2002) (noting that strength of Do-Not-Resuscitate (DNR) order recommendations varies with medicine specialty, years of training and experience).

24. S.D. Nightingale & M. Grant, *Risk Preference and Decisionmaking in Critical Care Situations*, 93 CHEST 684, 684 (1988).

25. See Neil Wenger & Sara Carmel, *Physicians' Religiosity and End-of-Life Care Attitudes and Behaviors*, 71 MOUNT SINAI J. MED. 335, 335 (2004) (noting that "[v]ery religious physicians, compared to moderately religious and secular physicians, were much less likely to believe that life-sustaining treatment should be withdrawn . . . , to approve of prescribing needed pain medication if it will hasten death . . . , or to agree with euthanasia . . .").

26. H. Hinkka et al., *Factors Affecting Physicians' Decisions to Forgo Life-sustaining Treatments in Terminal Care*, 28 J. MED. ETHICS 109, 109 (2002).

27. Nicholas Christakis & Davis Asch, *Biases in How Physicians Choose to Withdraw Life Support*, 342 LANCET 642, 642 (1993) (identifying four physician biases with regard to the withdrawal of life-sustaining treatment). For example, researchers exploring various specialists' willingness to use life-sustaining treatments, reviewed the care of 151 patients with end stage diseases. Hanson et al., *supra* note 23, at 785. Although the patients' prognoses were very similar, the researchers found that cardiologists were consistently more willing to use life-sustaining treatments and were the least likely to issue an order to withhold treatment. *Id.* Alternatively, oncologists rarely used life-sustaining treatments, and issued orders to withhold treatments more frequently. *Id.* A study of cross-specialty variability in end-of-life practices in a pediatric setting has also revealed marked differences in decision-making among specialists.

28. See Catherine M. Breen et al., *Conflict Associated With Decisions to Limit Life-Sustaining Treatment in Intensive Care Units*, 16 J. GEN. INTERNAL MED. 283, 286 (2001).

29. See Sonia Frick et al., *Medical Futility: Predicting Outcome of Intensive Care Unit Patients by Nurses and Doctors—A Prospective Comparative Study*, 31 CRIT. CARE MED. 456, 460 (2003). In another study, disagreements with respect to treatment strategies for terminally ill ICU patients arose in two-thirds of the patients studied. *Id.* at 459 (noting that the sicker ICU patients were and the longer they stayed in the ICU, the more the predictions about future quality of life by physicians and nurses diverged.)

process of making end-of-life decisions.<sup>30</sup>

### END-OF-LIFE DECISION-MAKING AND PROVIDER-FAMILY CONFLICTS

Considering the variability of end-of-life practices, the incidence of disagreement among health care providers, and the frequency with which families report communication failures,<sup>31</sup> it is also not surprising that significant provider-family conflicts arise with some frequency when the withholding or withdrawal of life-support is considered.<sup>32</sup> In a 2001 study of ICU patients for whom the withdrawal of life-support was proposed, disagreements between providers and family members occurred in almost half the cases.<sup>33</sup> However, research also indicates that the majority of such disagreements occurred when providers implemented or continued treatment despite patient or family preferences to pursue less aggressive care.<sup>34</sup> Disputes in which

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30. See, e.g., Edouard Ferrand et al., *Discrepancies Between Perceptions by Physicians and Nursing Staff of Intensive Care Unit End-of-Life Decisions*, 167 AM. J. RESPIR. CRIT. CARE MED. 1310, 1310 (2003) (describing a survey in which 73% of ICU physicians described end-of-life decision-making processes as satisfactory, but only 33% of the ICU nursing staff agreed. Although 90% of providers believed decision-making should be collaborative, only 50% of physicians and 27% of nurses believed that such collaboration existed.).

31. See Sally Norton et al., *Life Support Withdrawal: Communication and Conflict*, 12 AM. J. CRITICAL CARE 548 (2003); Breen et al., *supra* note 28, at 287 (noting that communication problems were primary source of identified provider-family conflicts in 46% of cases). See also E. Azoulay et al., *Half the Families of ICU Patients Experience Inadequate Communication with Physicians*, 8 CRITICAL CARE MED. 3044 (2000) (noting, as the title suggests, that significant numbers of families do not have adequate communication with physicians. Note, however, that this study was conducted in France and may or may not present data relevant to practice in the United States); A.P. Abernethy & J.A. Tulsky, *Disagreements That Arise When Making Decisions About Withdrawing or Withholding Life-Sustaining Treatment*, 12 (Apr. Supp.) J. GEN. INTERNAL MED. 101 (1997). See Joan Teno et al., *Family Perspectives on End-of-Life Care at the Last Place of Care*, 291 JAMA 88 (2004) (describing an end-of-life care survey in which over 50% family members whose loved ones had died in a hospital reported not having adequate contact with physicians); *Id.* at 91.

32. See Thomas Prendergast & Kathleen Puntillo, *Withdrawal of Life Support: Intensive Caring at the End of Life*, 288 JAMA 2732, 2732 (2002) (noting that decisions concerning life-sustaining treatments are "often a source of disagreement"). *Id.* at 2732. Conflicts also arise between family members or between the patient and family members. See Breen et al., *supra* note 28, at 286.

33. See Breen et al., *supra* note 28, at 286.

34. See *id.* In the 2001 study, 76% of the provider-family conflicts identified involved

patients or family members rejected withholding or withdrawal recommendations and sought to continue aggressive treatment occurred with much less frequency.<sup>35</sup>

Regardless of the nature of the disagreement, in the majority of conflicts providers and family members are able to reach consensus. However, substantial differences in cultural, religious, or scientific views<sup>36</sup> and mistrust of medical professionals<sup>37</sup> often contribute to the deterioration of such conflicts into intractable disputes. Communication failures,<sup>38</sup> the inaccessibility of health care providers,<sup>39</sup> and a general lack of patient and family involvement in decision-making<sup>40</sup> are also

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cases in which the staff wanted a more aggressive approach; 24% involved cases in which the family wanted to continue aggressive treatment. *Id.* See also Asch et al., *supra* note 13, at 288 (reporting that 34% of ICU physicians surveyed reported that they had continued life-sustaining treatment over the objections of patients and family members); Joan Teno et al., *Medical Care Inconsistent With Patients' Treatment Goals: Association With 1-year Medicare Resource Use and Survival*, 50 J. AM. GERIATR. SOC. 496, 496 (2002) (finding "86% of the patients who wanted aggressive treatment reported that care was consistent with their preferences, but only 41% of those who preferred comfort care reported that care was consistent with their preferences. More than one-third of those with a preference for comfort care (35%) reported that the medical care that they received was inconsistent with their goals.") *Id.* at 496.

35. *Id.*

36. See Prendergast & Puntillo, *supra* note 70, at 2737; Allan S. Brett & Paul Jersild, "Inappropriate" Treatment Near the End of Life: Conflict Between Religious Convictions and Clinical Judgment, 163 ARCH. INTERNAL MED. 1645 (2003); R.D. Orr & L.B. Genesen, *Requests for Inappropriate Treatment Based on Religious Beliefs*, 23 J. MED. ETHICS 142 (1997); J. Kunin, *Withholding Artificial Feeding From the Severely Demented: Merciful or Immoral? Contrasts Between Secular and Jewish Perspectives*, 29 J. MED. ETHICS 208 (2003).

37. Renowned ethicist Arthur Caplan contends that mistrust of medical professionals plays a central role to provider-family conflicts involving futility and cannot be ignored in any medical futility debate. See Arthur L. Caplan, Editorial, *Odds and Ends: Trust and the Debate over Medical Futility*, 125 ANNALS INTERNAL MED. 688 (1996); see also Leigh Turner, *Recognizing the Persistence of an Ethical Conflict: Disputes Concerning What Constitutes Appropriate Levels of Care: Part II*, 12 ANNALS LONG-TERM CARE 21 (2004) ("[B]reakdowns in trust between patients . . . and clinicians can leave patients or family members reluctant to accept the recommendations of physicians.") *Id.*

38. See Norton et al., *supra* note 31; Breen et al., *supra* note 28, at 287 (noting that communication problems were primary source of identified provider-family conflicts in 46% of cases). See also E. Azoulay et al., *Half the Families of ICU Patients Experience Inadequate Communication with Physicians*, 8 CRITICAL CARE MED. 3044 (2000)

39. See Joan Teno et al., *Family Perspectives on End-of-Life Care at the Last Place of Care*, 291 JAMA 88 (2004) (describing an end-of-life care survey in which over 50% of family members reported inadequate contact with physicians.) *Id.* at 91.

40. See Joan Teno et al., *Decision-making and Outcomes of Prolonged ICU Stays in Seriously Ill Patients*, 48 J. AM. GERIATRIC SOC'Y S70 (2000) (reporting that of over 9000

problematic.

Although provider-family disagreements are not unanticipated and "can be constructive, uncovering differences in values and legitimate concerns that have been inadequately discussed,"<sup>41</sup> when such disagreements deteriorate into full conflict, they become extremely burdensome for providers, patients and family members.<sup>42</sup> For providers, intractable disagreements can be demoralizing<sup>43</sup> and a potent source of anger and frustration.<sup>44</sup> For patients and family members, disputes generate considerable distress, leading to anxiety, anger, distrust, and may ultimately complicate the bereavement process.<sup>45</sup> Researchers have noted, "even minor conflicts that were ultimately resolved generated considerable psychological turmoil."<sup>46</sup>

## II. UNILATERAL WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT BASED ON MEDICAL FUTILITY

### *INSTITUTIONAL AND STATUTORY FUTILITY POLICIES*

Beginning in the early 1990's, policy supporters and professional organizations promoted the concept of futility and advocated for the development of institutional policies intended to address conflicts in which patients or family members request treatment that providers deem "futile."<sup>47</sup> The American Medical

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patients surveyed, less than 40% of patients or their surrogates reported that their physicians had discussions with them about their prognoses or their preferences for life-sustaining treatment.) *Id.*

41. Jenny Way et al., *Withdrawing of Life Support and Resolution of Conflicts With Families*, 325 BRIT. MED. J. 1342, 1345 (2002).

42. A.P. Abernethy & J.A. Tulsky, *Disagreements That Arise When Making Decisions About Withdrawing or Withholding Life-Sustaining Treatment*, 12 J. GEN. INTERN. MED. (Apr. Supp.) 101, 101 (1997).

43. Stanley Nasraway, *Unilateral Withdrawal of Life-Sustaining Therapy: Is It Time? Are We Ready?* 29 CRIT. CARE MED. 215, 215 (2001).

44. Joseph d'Oronzio, *Determining Futility*, 12 CAMBRIDGE. Q. HEALTHCARE ETHICS 214, 217 (2003) ("Caregivers providing what they think is morally questionable care, feel professionally disenfranchised and experience a mix of anguish and anger. . . .").

45. Abernethy & Tulsky, *supra* note 30, at 101.

46. *Id.*

47. See, e.g., D.R. Gregory, *VA Network Futility Guidelines: A Resource for Decisions*

Association's (AMA's) Council for Ethical and Judicial Affairs asserted, "[A]ll health care institutions, whether large or small, should adopt a policy on medical futility."<sup>48</sup>

Despite decades of widespread discussion and numerous attempts to identify the circumstances in which a medical intervention can be described as "futile," commentators have been unable to agree on a practical, objective definition.<sup>49</sup> In an attempt to provide guidance in identifying futile medical interventions, commentators and practitioners have offered a wide range of definitions.<sup>50</sup> A "futile" medical treatment has been described as an intervention: that is useless or ineffective;<sup>51</sup> that has an unacceptably low chance of achieving a therapeutic benefit;<sup>52</sup> that serves no useful purpose in attaining a specified goal;<sup>53</sup> that cannot achieve the patient's wishes or goals;<sup>54</sup> that cannot improve the patient's prognosis, comfort, well-being, or general state of health;<sup>55</sup> that cannot end dependence on

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*About Withholding and Withdrawing Treatment*, 4 CAMBRIDGE Q. HEALTHCARE ETHICS 546, 546 (1995); D. Murphy & E. Barbour, *Guide (Guidelines for the Use of Intensive Care in Denver): A Community Effort to Define Futile and Inappropriate Care*, 2 NEW HORIZONS 326, 326 (1994); Bay Area Network of Ethics Committees (BANEC) Nonbeneficial Treatment Working Group, *Nonbeneficial or Futile Medical Treatment: Conflict Resolution Guidelines for the San Francisco Bay Area*, 170 WESTERN J. MED. 287, 287-290 (1990); *See also infra* notes 120-125 and accompanying text.

48. *Id.*

49. *See* Council on Ethical and Judicial Affairs, *supra* note 10, at 937-938 (reviewing the various approaches for identifying a medically futile intervention and the criticisms of each); Kathryn Moseley et al., *Futility in Evolution*, 21 CLINICS GERIATR. MED. 211, 213 (2005) (describing four different approaches to defining futility); Paul Helft et al., *The Rise and Fall of Futility Movement*, 343 NEW ENG. J. MED. 293, 295 (2000); *see also* Caplan, *supra* note 37, at 688 (noting that "analysis of the concept has failed to produce a consensus about how it should be defined or used"); R. Löfmark & T. Nilstun, *Conditions and Consequences of Medical Futility—From a Literature Review to a Clinical Model*, 28 J. MED. ETHICS 115, 115 (2002).

50. *See generally* Ardagh, *supra* note 9, at 397.

51. *See* Ian Kerridge et al., *Competent Patients, Incompetent Decisions*, 123 ANNALS INTERN. MED. 878, 879 (1995).

52. Lawrence Schneiderman, *Medical Futility and Aging: Ethical Implications*, GENERATIONS, Vol. 18, No. 4 at 61, 62 (Winter, 1994).

53. Deborah L. Kasman, *When Is Medical Treatment Futile? A Guide for Students, Residents, and Physicians*, 19 J. GEN. INTERN. MED. 1053, 1053 (2004).

54. *Id.*

55. Lawrence Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTER. MED. 949, 951-953 (1990) [hereinafter *Medical Futility*].

intensive medical care;<sup>56</sup> that is highly unlikely to result in meaningful survival;<sup>57</sup> that does not offer a reasonable chance of survival;<sup>58</sup> that merely prolongs dying;<sup>59</sup> that is so unlikely to succeed that many people would not consider it worthwhile;<sup>60</sup> or that fails to offer a minimum quality of life or medical benefit.<sup>61</sup>

Ultimately, the significant theoretical and practical differences in proposed definitions led commentators to conclude that medical futility is "an elusive concept,"<sup>62</sup> and that the struggle to achieve a practical definition of "futile treatment" is itself futile.<sup>63</sup> AMA's Council on Ethical and Judicial Affairs concluded that futility is "inherently a value-laden determination," therefore, "[a] fully objective and concrete definition of futility is unattainable."<sup>64</sup>

Nonetheless, supporters continued to advocate for futility policies, contending that the lack of an accepted definition is not problematic because "most physicians now know it when they see it."<sup>65</sup> Throughout the 1990's many institutions and

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56. *Id.* at 949.

57. American Thoracic Society, *Withholding and Withdrawing Life-Sustaining Therapy*, 115 ANNALS INTERN. MED. 478, 481 (1991).

58. See Kerridge, *supra* note 51, at 879.

59. See Council on Ethical and Judicial Affairs, *supra* note 10, at 938.

60. Donald Murphy & Thomas Finucane, *New Do-Not-Resuscitate Policies: A First Step in Cost Control*, 152 ARCHIVES INTERN MED. 1641, 1644 (Jul. 26, 1993).

61. John Lantos et al., *The Illusion of Futility in Clinical Practice*, 87 AM. J. MED. 81, 82 (1989).

62. *Id.* at 83.

63. E. Haavi Morreim, *Profoundly Diminished Life: The Causalities of Coercion*, 24 HASTINGS CENTER REPORT 33, 33 (1994); see also R. Gillon, 'Futility'—Too Ambiguous and Pejorative a Term? 23 J. MED. ETHICS 338, 340 (1997) (asserting "some words in medicine [such as "futile"] have acquired so much pejorative baggage that they are probably best regarded as medically obsolete, and consigned to the medical history books"); *Id.* at 340. In a 1991 report, the Council on Ethical and Judicial Affairs (CEJA) of the American Medical Association expressed concern regarding the use of futility as a basis for withholding cardiopulmonary resuscitation (CPR). See Council on Ethical and Judicial Affairs, *Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders*, 265 JAMA 1868, 1879 (1991). The Council noted significant variability among physicians with regard to what constitutes futility, with some describing futility as a treatment with zero percent chance of success, while others associate futility with success rates as high as thirteen percent. *Id.* (citations omitted). The Council added, "[d]eterminations of futility also may vary...based on the perceived objectives of medical treatment and the criteria that are used to evaluate outcome." *Id.*

64. See Council on Ethical and Judicial Affairs, *supra* note 10, at 938.

65. See Fine & Mayo, *Advance Directive, Due Process, and Medical Futility*, 150

organizations adopted futility policies,<sup>66</sup> but the content of such policies varies considerably. Some policies allow health care providers to withhold or withdraw life-sustaining medical treatment without the consent of the patient or a family member. For example, a 1991 statement of the American Thoracic Society entitled "Withholding and Withdrawing Life-Sustaining Therapy" provides:

[A] life-sustaining intervention may be withheld or withdrawn from a patient without the consent of the patient or the surrogate if the intervention is judged to be futile. A life-sustaining treatment is futile if reasoning and experience indicate that the intervention would be highly unlikely to result in meaningful survival for that patient.<sup>67</sup>

Other policies provide that treatments deemed "inappropriate" or "medically ineffective" may be withheld or withdrawn.<sup>68</sup> A handful of states incorporated "medically ineffective care" provisions from the Uniform Health-Care Decisions Act (UHCDA) into their laws.<sup>69</sup> In 1999, the Texas

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ANNALS OF INTERNAL MEDICINE 404 (2004).

66. See generally Johnson et al., *supra* note 10.

67. American Thoracic Society, Medical Section of the American Lung Association, *Withholding and Withdrawing Life-Sustaining Therapy*, 144 AM. REV. RESPIR. DISEASE 726, 728 (1991).

68. CAL. PROB. CODE § 4735 (Westlaw through 2006 legislation).

69. At publication, eight states have adopted the medically ineffective care provisions of the UHCDA: Alaska, California, Delaware, Hawaii, Maine, Maryland, Mississippi, and New Mexico. ALASKA STAT. § 13.52.060(f) (Westlaw through 2005 legislation); CAL. PROB. CODE § 4735 (Westlaw through 2006 legislation); DEL. CODE ANN. tit. 16, §2508 (Westlaw through 2005 Sess.); HAW. REV. STAT. ANN. § 327E-7 (Westlaw through 2004 legislation); ME. REV. STAT. ANN. tit. 18-A § 5-807 (Westlaw through 2005 legislation); MD. CODE ANN., HEALTH-GEN. I § 5-611 (Westlaw through 2006 legislation); MISS. CODE ANN. § 41-41-215 (Westlaw through 2005 legislation); N.M. STAT. ANN. § 24-7A-7 (Westlaw through 2005 legislation). National Conference of Commissioners on Uniform State Laws, Uniform Health-Care Decisions Act (1993) at 1, available at <http://www.law.upenn.edu/bll/ulc/fnact99/1990s/uhcda93.pdf> In 1993, the National Conference of Commissioners on Uniform State Laws recognized that the promulgation of state advance directives laws had resulted in rules that were fragmented and inconsistent. The Commissioners developed the UHCDA in an attempt to provide consistent guidelines. The UHCDA defines "medically ineffective" interventions as "treatment which would not offer the patient any significant benefit" (*See id.* at §7 Comment) but does not describe the necessary process for withholding or withdrawing life-sustaining treatments over the objections of a patient or family member, except that the decision must be communicated to family members, providers must assist in attempting to find a transfer facility, and the treatment must be continued while an attempt to locate an alternative facility is made. *See*

Legislature created a statutory futility policy that allows health care providers to remove life-sustaining treatment over the objections of the patient or family members.<sup>70</sup> The Texas Advance Directives Act grants immunity from disciplinary action and criminal and civil liability to health professionals who follow a statutorily prescribed procedure for "failing to effectuate" a patient's or surrogate's medical treatment decision.<sup>71</sup> Under the statute, health care providers can unilaterally withhold or withdraw any treatment that providers believe to be "inappropriate."<sup>72</sup>

Statutory policies are subject to public scrutiny, but unfortunately, published data describing the prevalence and content of institutional futility policies is quite limited; the extent to which such policies comply with published professional guidelines is largely unknown.<sup>73</sup> The limited data regarding the content of institutional futility policies is mostly contained in a research study published in 1997.<sup>74</sup> In this survey, a team of researchers examined 115 medical futility policies from hospitals across the nation.<sup>75</sup> The authors described significant differences

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generally C.M. Galambos, *Preserving End-of-Life Autonomy: The Patient Self-Determination Act and the Uniform Health Care Decisions Act*, 23 HEALTH & SOC. WORK 275, 275 (1998). David M. English, *The Uniform Health Care Decisions Act and Its Progress in the States*, 15 ABA PROB. & PROP. 19, 19-20 (May-Jun. 2001) (reviewing the utilization of the UHCDA by states). The UHCDA contains provisions that permit physicians to withhold or withdraw treatment contrary to a patient or surrogate's preferences for reasons of conscience or when the physician determines that the treatment would be "medically ineffective or contrary to generally accepted health-care standards."

70. See TEXAS HEALTH & SAFETY CODE ANN. § 166.045(d) (Westlaw through 2005 legislation).

71. TEXAS HEALTH & SAFETY CODE ANN. § 166.045(d) provides: "A physician, health professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the person's appropriate licensing board if the person has complied with the procedures outlined in Section 166.046."

72. This term is not defined in the statute. See *id.*

73. See Lawrence Schneiderman & Alexander Morgan Capron, *How Can Hospital Futility Policies Contribute to Establishing Standards of Practice?* 9 CAMBRIDGE Q. HEALTHCARE ETHICS 524, 529 (2000) ("No data exist on futility policies adopted by hospitals in California, much less across the nation.).

74. See Johnson et al., *supra* note 10, at 27. Generally, organizational and community policies appear more accessible, with many available on the internet. Institutional policies are less accessible.

75. *Id.* Researchers sent surveys to 1,990 U.S. hospitals with more than 200 beds. Approximately 485 (28%) of the hospitals responded. *Id.* Of the respondents, 137 (26%)



in the policies and identified a number of aspects in which they found the policies lacking.<sup>76</sup>

Researchers noted that most of the policies did not attempt to identify the circumstances in which treatment should be described as futile, and those that did offered widely varying definitions.<sup>77</sup> The authors also noted significant variations in the procedural aspects of the examined policies; some policies emphasized the decision-making authority of physicians while others provided that the patient or surrogate had the ultimate decision-making authority.<sup>78</sup> Policies also differed in that some promoted extensive negotiation between interested parties, but others merely provided that physicians need not provide treatment deemed futile.<sup>79</sup>

Provisions requiring the involvement of institutional ethics committees were also a source of dissimilarity in the policies.<sup>80</sup> Although many policies *recommended* consulting an institutional ethics committee, very few policies specifically *required* the committee's involvement.<sup>81</sup> Those that did require ethics committee involvement did so under very limited circumstances.<sup>82</sup> Finally, researchers noted that while most of the reviewed policies explicitly stated that the provider must inform the patient or surrogate of the futility judgment, some only recommended informing the patient or surrogate, and others made no provision for the disclosure of futility judgments, again merely stating that the physician need not

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stated that they has explicit, written medical futility policies, 115 (84%) of these hospitals forwarded copies of their policies to researchers. *Id.* The authors reported only on those policies that were clearly identified as medical futility policies and that went beyond the question of issuing of Do-Not-Resuscitate orders. *Id.* None of the policies were identified by state and at present there are no published reports describing the prevalence or content of futility policies in Wisconsin.

76. *Id.* at 27-29.

77. *Id.*

78. *Id.* at 30.

79. *See id.*

80. *Id.* at 31.

81. *Id.*

82. *Id.*

offer treatment deemed “futile” or “inappropriate.”<sup>83</sup>

A disturbing lack of information about the use of both institutional and statutory futility policies exists.<sup>84</sup> At the writing of this essay, no reports surveying the circumstances in which institutional futility policies have been invoked have been published.<sup>85</sup> In 2003, ethics consultants at Baylor University Medical Center in Dallas published a short paper describing their experience with the Texas law.<sup>86</sup> In the report, the authors described six cases that proceeded through the statutory mechanism.<sup>87</sup> Of the six cases, three families agreed to withdraw support shortly after receiving the written report of the ethics committee; two patients died during the ten day waiting period without having found an alternative provider; and one patient, for whom a transfer facility had been located, died while awaiting transfer.<sup>88</sup> However, the Baylor report included clinical information about only one of the patients and did not describe the providers involved or the interventions that were the subject of dispute.<sup>89</sup>

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83. *Id.* at 30.

84. *See id.*

85. *See* Asch et al., *supra* note 13, at 289 (noting “the empirical research that could help define current physician practice in this area is almost exclusively anecdotal”).

86. Robert Fine & Thomas W. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directive Act*, 138 ANNALS INTERN. MED. 743, 743 (2003).

87. *Id.* at 745.

88. *Id.*

89. *Id.* More recently, the local media has reported on the application of the Texas law, which has resulted in at least some documentation of the circumstances giving rise to disputes. For example, in 2005, a hospital acting pursuant to the Texas statute removed a critically ill infant from life support over the objections of his mother. *See* Bruce Nichols, *Hospital Ends Life Support of Baby: 1st U.S. Case of Its Kind is Against Mom's Wish, in Accordance With Law*, DALLAS MORNING NEWS, Mar. 16, 2005, at 1A. The infant, Sun Hudson, was born in September, 2004 with thanatophoric dysplasia, a genetic defect that results in impaired lung and chest development. *See* Case Digest, *Hudson v. Texas Children's Hospital: Houston's First Circuit Court of Appeals: Civil Practice*, 21(2) Texas Lawyer 31 (2005). Shortly after birth, Sun's physicians placed him on a ventilator. *Id.* Later, physicians recommended that the ventilator be removed, contending that continued ventilatory support was futile, and therefore ethically and medically inappropriate. *Id.* Sun's mother disagreed with the recommendation to withdraw the ventilator and sought a court order preventing the withdrawal. *Id.* An appellate court barred the removal until a procedural issue could be resolved, but upon resolution of the procedural problem, Ms. Hudson's attorney reported that he did not have the resources to pursue other legal actions. A court lifted a restraining order that prevented the hospital from removing of life-sustaining

**ETHICAL ASPECTS OF UNILATERAL WITHHOLDING OR  
WITHDRAWAL BASED ON MEDICAL FUTILITY**

In addition to the lack of consensus regarding the identification of "futile" medical interventions and the paucity of information about the content and use of futility policies, opinions diverge about the use of medical futility as an ethical justification for unilateral decision-making.<sup>90</sup> In generally, four bioethical principles have gained widespread acceptance in the analysis of ethical issues that arise in medicine: respect for autonomy, beneficence, nonmaleficence and justice.<sup>91</sup> While each of these principles describes an important moral duty, the individual duties are not absolute.<sup>92</sup> Instead, each principle describes a *prima facie* obligation that must be balanced with the demands of competing moral considerations.<sup>93</sup> Under the principalist approach, the obligations of health care providers are determined by a thoughtful weighing of these sometimes conflicting imperatives. Ultimately, clinicians must consider and weigh each imperative, determine which principle or

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treatment. The infant's mother initially secured a court order barring the removal, but after multiple attempts to transfer the infant failed, the mother's attorney reported that he did not have the resources to pursue other legal action. See Leigh Hopper, *Life-Support to be Shut Off Today: Mother's Lawyer Says He Has No Plans to Appeal Hospital's Decision*, HOUSTON CHRON., Mar. 15, 2005, at 1B (Newspaper accounts state that the hospital involved encouraged Ms. Hudson to pursue legal action and offered to pay her attorney.). The hospital removed the ventilator, followed shortly thereafter by the death of the infant. See Nichols, *supra* at 1A.

90. See Asch et al., *supra* note 13, at 288 & 291 (stating "[i]t is doubtful that ethical principles regarding the appropriate practical definition of medical futility will ever be noncontroversial").

91. The principalist approach was developed by professors Tom Beauchamp and James Childress in their seminal text. See generally TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4<sup>th</sup> ed. 1994). Later, this approach was adopted by influential governmental ethics commissions. See National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (1978) available at <http://ohsr.od.nih.gov/guidelines/belmont.html>. The principalist approach has often been used to analyze the ethical justification of unilateral actions based on medical futility. See, e.g., John Luce, *Physicians Do Not Have a Responsibility to Provide Futile or Unreasonable Care If a Patient or Family Insists*, 23 CRIT. CARE MED. 760, 760 (1995) (briefly describing and applying the four principles of autonomy, beneficence, nonmaleficence, and justice).

92. BEAUCHAMP & CHILDRESS, *supra* note 91, at 126.

93. *Id.*

principles are most significant under the circumstances, and choose a course of action that best reflects these principles.<sup>94</sup>

Futility policy supporters assert that physicians are ethically justified in unilaterally withholding or withdrawing life-sustaining treatments on the basis of medical futility because such actions are supported by the ethical principles of beneficence, nonmaleficence, and justice.<sup>95</sup> Supporters of physician discretion also contend that the principle of respect for patient autonomy, while relevant to the analysis, does not create a positive right to demand specific treatment.<sup>96</sup> In addition, policy supporters argue that the issue of whether a particular treatment's benefit is substantial enough to render it a viable option is a matter of professional judgment and integrity.<sup>97</sup>

Critics respond that the use of medical futility as a basis for the unilateral withdrawal of life-sustaining treatments is not sufficiently justified by claims of beneficence, justice, or professional integrity and that advocates of medical futility policies unacceptably neglect the duty to respect patient autonomy.<sup>98</sup> According to these critics, an appeal to futility does not adequately justify unilateral action and "the rapid advance of the language of futility. . . should be followed by an equally rapid retreat."<sup>99</sup>

#### BENEFICENCE AND NONMALEFICENCE

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94. *Id.*

95. *See* Luce, *supra* note 91, at 760.

96. *See* Clare M. Clarke, *Do Parents of Surrogates Have the Right to Demand Care Treatment Deemed Futile? An Analysis of the Case of Baby L.*, 32 J. ADVANCED NURSING 757,758 (2000).

97. *See infra* notes 110-115.

98. *See* Moseley et al., *supra* note 49, at 214.

99. *See* Robert Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560, 1563 (1992). How patients feel about providers' invocation of medical futility to justify unilateral decisionmaking has not been extensively studied. *But see* J. Randall Curtis, *The Attitudes of Patients With Advanced AIDS Toward the Use of Medical Futility Rationale in Decisions to Forgo Mechanical Ventilation*, 120 ARCHIVES INTERN. MED. 1597, 1600 (2000) (reporting that in a survey of 57 patients with advanced AIDS, the majority of patients (61%) accepted the use of medical futility as a rationale for withholding mechanical ventilation, but a substantial minority (12%) did not).

The principle of beneficence requires that physicians act in ways that promote the well-being of their patients.<sup>100</sup> The principle of nonmaleficence is a complementary imperative. While beneficence implies a positive duty to act in accordance with patient interests, nonmaleficence imposes a duty on physicians to avoid actions that may result in unnecessary harm.<sup>101</sup>

Policy supporters assert that the discretion to make futility judgments is essential to a physician's adherence to the ethical obligations of beneficence and nonmaleficence.<sup>102</sup> According to this view, physicians are only morally obligated to provide care that has a reasonable chance of achieving some therapeutic benefit.<sup>103</sup> Because interventions deemed futile provide little or no substantial benefit, physicians are not ethically obligated to provide them.<sup>104</sup> Furthermore, because futile interventions may involve a potential risk of harm, the provision of such treatment violates the principle of nonmaleficence.<sup>105</sup>

However, critics contend that reliance on the ethical principles of beneficence and nonmaleficence as justification for decision-making that is opposed to patient or family preferences is flawed.<sup>106</sup> According to these critics, physicians are indeed obligated to act in ways that benefit patients, but the question of whether an intervention provides a significant benefit is an inherently subjective and value-laden determination.<sup>107</sup> As a result, such decisions are best made by the patient himself, or by

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100. See BEAUCHAMP & CHILDRESS, *supra* note 91, at 260.

101. See generally BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS 12 (2d ed. 2000).

102. See Lawrence Schneiderman et al., *Medical Futility: Response to Critiques*, 125 ANNALS INTERN. MED. 669, 670 (1996) [hereinafter *Response to Critiques*] (stating "the power to make judgments about futility is a necessary part of the physician's duty of beneficence").

103. See *id.* See also W. Daniel Doty & Robert Walker, *Medical Futility*, 23 CLINICAL CARDIOLOGY (Supp. II) II-6, II-6 (2000).

104. See *id.*

105. See Schneiderman, *Response to Critiques*, *supra* note 102, at 670.

106. See Frick et al., *supra* note 29, at 459-460.

107. *Id.* at 459 (The only common feature of futility judgments is that they inherently involve of a question of benefit, which necessarily implies a value judgment on the part of the physician.).

someone who is intimately familiar with the patient's personal beliefs and values.

While health care professionals make important contributions to discussions regarding end-of-life treatment by providing essential information about treatment alternatives and potential risks and benefits, they are ill-equipped to determine how these variables will be interpreted and weighed by individual patients. In fact, research demonstrates that physicians often have poor understandings of patient preferences and that most patients do not discuss their personal values or treatment preferences with their physicians.<sup>108</sup> As a result, what a patient regards as worthwhile may differ substantially from the physician's assessments, and a physician who acts contrary to a patient's or family member's assessment of benefit merely substitutes his or her personal values for those of the patient or family member.

For example, a physician may conclude that long-term ventilator support for a patient suffering from a terminal illness is futile because he believes that it will not change the outcome, but may increase suffering and prolong the dying process. However, a patient may be willing to accept the burdens of the ventilator due to deeply held religious beliefs, or simply because it will allow him to spend a little more time with his family. A physician can assert no ethical grounds that his or her assessment of the potential benefit is preferable and should control.

Critics also assert that allowing a provider-driven assessment of benefit to dominate decision-making is problematic because empirical studies have repeatedly demonstrated that physicians' predictions of their patients' future quality of life are inaccurate and unreliable.<sup>109</sup> For

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108. Kenneth Covinsky et al., *Communication and Decisionmaking in Seriously Ill Patients: Findings of the SUPPORT Project*, 48 J. AM. GERIATR. SOC., (Supp. 5) S187, S187 (2000) (finding "[p]hysician, nurse, and surrogate understanding of their patient's preferences is only moderately better than chance").

109. See Susan Goold et al., *Conflicts Regarding Decisions to Limit Treatment: A Differential Diagnosis*, 283 JAMA 909, 912 (2000) ("Physicians tend to underestimate chronically ill patients' quality of life, and are more likely than patients or families to think

instance, in a 2003 study, researchers collected data describing physicians' and nurses' predictions of their patients' futures, including their opinions about whether treatment should be discontinued.<sup>110</sup> The authors later compared the findings to data obtained during follow-up interviews with former patients.<sup>111</sup> The researchers found, "Neither nurses nor doctors could reliably predict who would be satisfied with his or her [quality of life] QOL 6 months after ICU admission."<sup>112</sup> The authors concluded that health care providers cannot accurately predict quality of life,<sup>113</sup> and they advised "[u]tmost caution has to be applied when future QOL as presumed by nurses and doctors is used as an argument for withholding or withdrawing further treatment."<sup>114</sup>

## JUSTICE

The principle of justice is an important consideration, particularly when the intervention in question is expensive. This principle requires that physicians make judicious use of limited health care resources and attempt to ensure fairness in the distribution of such resources.<sup>115</sup> Supporters of medical futility policies assert that the provision of futile medical treatment violates this principle by investing valuable resources in treatment that will not produce favorable outcomes, while others struggle to obtain access to even basic care.<sup>116</sup>

Meanwhile, critics maintain that reliance on the principle of

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such patients would choose to forgo life-sustaining treatment." Bekele Afessa et al., *Identifying Potentially Ineffective Care in the Sickest Critically Ill Patients on the Third ICU Day*, 126 CHEST 1905, 1905 (2004) ("A number of studies have reported poor performance of critical care providers in predicting futility of care."). Truog et al., *supra* note 99, at 1561 ("[P]hysicians are often highly unreliable in estimating the likelihood of success of a therapeutic intervention.").

110. Frick et al., *supra* note 29, at 456.

111. *Id.*

112. *Id.* at 459.

113. *Id.* at 459-460.

114. *Id.* at 460.

115. See LO, *supra* note 101, at 13.

116. See generally Luce, *supra* note 91, at 764 (discussing the principle of justice in relation to futility).

justice is misguided because unilateral end-of-life decision-making is not a legitimate means of resource allocation. First, there is little empirical evidence that eliminating "futile" treatment will result in significant cost savings,<sup>117</sup> particularly when compared to other potential cost-cutting measures.<sup>118</sup>

[E]ven if life-sustaining treatment had been withdrawn from all patients in the SUPPORT study [a well known end-of-life study involving over four thousand patients]... it would have resulted in only a 13% reduction in costs for the entire cohort. . . . This cost savings would be minimal compared with eliminating other highly cost-ineffective interventions that may be provided more frequently with less grave consequences. . . .<sup>119</sup>

Even if a substantial reduction in costs could be realized, any "savings" achieved from the withdrawal of treatment from an individual patient is not necessarily channeled to other supposedly more worthwhile patients.<sup>120</sup> Critics acknowledge that end-of-life medical care can be extremely costly, but they argue that any decision to reallocate resources should be made as a matter of public policy and subject to public scrutiny.<sup>121</sup> They also assert that while the expertise of physicians is essential

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117. See Amir Halevy et al., *The Low Frequency of Futility in An Adult Intensive Care Unit Setting*, 156 ARCHIVES INTERN. MED. 100 (Jan. 8, 1996) (abstract) ("The frequency of futile interventions appears to be low unless one is willing to accept a definition that includes patients who could survive for many months. If confirmed in other settings, this suggests that concepts of futility will not play a major role in cost containment."). See also Alexander Capron, *Medical Futility: Strike Two*, 25 HASTINGS CENTER REPORT 42, 43 (Sept. 1994) (noting that "evidence is beginning to accumulate that cutting futile care offers no great savings," and asserting "medical futility" . . . lacks the economic payoff that some might see as a legitimate trade-off for its ethical problems."). Marion Danis et al., *A Prospective Study of the Impact of Patient Preferences on Life-Sustaining Treatment and Hospital Cost*, 24 CRIT. CARE MED. 1811, 1817 (1996) (noting that "there is little systematic evidence that patient treatment preferences generally influence actual treatment use or cost;" therefore, "futility policies that override patient wishes may yield little savings and much divisiveness").

118. John Luce & Gordon Rubenfeld, *Can Health Care Costs be reduced by Limiting Intensive Care at End of Life?* 165 AM. J. RESPIR. CRIT. CARE MED. 750, 750 (Mar. 15, 2002).

119. *Id.* at 752 (also noting, "[n]early all of this savings would have been attributable to care that would have been withdrawn from 12 patients, including younger patients and those with religious convictions not to have life support withdrawn").

120. See Moseley et al., *supra* note 49, at 214.

121. *Id.*



to public debate concerning allocation policies, physicians should avoid an attempt to apply such expertise to individual bedside rationing decisions.<sup>122</sup>

Because health care providers cannot agree on a practical definition of "futile" treatment and cannot accurately predict an individual patient's outcome, bedside resource-driven withholding or withdrawal decisions are vulnerable to individual biases and risk being characterized as arbitrary and unfair.<sup>123</sup> Interestingly, in a study that highlights the relationship between cost and the inability to identify "futile" treatment, the most expensive ICU patients were those who had a long length of stay in the ICU and had outcomes that were in opposition to what physicians originally predicted.<sup>124</sup> Thus, the care provided to those patients who were incorrectly predicted to die and those incorrectly predicted to live cost the most.<sup>125</sup> As a result, critics warn that using resource allocation rationale as a justification for withholding or withdrawing life-sustaining treatment from an individual patient will not be well-received and may ultimately undermine trust.

#### RESPECT FOR AUTONOMY

Respect for patient autonomy is the cornerstone of ethical decision-making in medicine and serves as the basis for the clearly established principle that a competent patient has the right to make decisions regarding his or her medical treatment.<sup>126</sup> Over a century ago, the U.S. Supreme Court emphasized the importance of respect for individual autonomy when it concluded that a person could not be ordered to submit to a surgical intervention.<sup>127</sup> The Court held, "No right is held more sacred, or is more carefully guarded . . . than the right of

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122. *Id.* at 214.

123. *See id.*

124. Allan Detsky et al., *Prognosis, Survival, and the Expenditure of Hospital Resources for Patients in an Intensive Care Unit*, 305 NEW ENG. J. MED. 667, 667 (1981).

125. *Id.*

126. *See* BEAUCHAMP & CHILDRESS, *supra* note 91, at 125.

127. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

every individual to the possession and control of his own person, free from all restraint or interference of others unless by clear and unquestionable authority of law."<sup>128</sup>

Supporters of futility policies recognize that unilateral decision-making by physicians appears to be an affront to this principle. However, they contend that the principle of autonomy confers a negative right to refuse unwanted treatments, but it does not imply a corresponding positive "right to demand" certain interventions.<sup>129</sup> For example, respect for autonomy does not require that a physician agree to provide antibiotics for a patient suffering from a viral infection. These policy supporters argue that the discretion to make decisions based on medical futility is necessary to correct excesses of patient autonomy,<sup>130</sup> and that maintaining the physician's discretion to make medical futility determinations is essential to professional integrity.<sup>131</sup>

According to Lawrence Schneiderman and his colleagues, medical futility is "a professional judgment that takes precedence over patient autonomy and permits physicians to withhold or withdraw care deemed to be inappropriate without subjecting such a decision to patient approval."<sup>132</sup> Accordingly, "[t]he treating physician's ethical obligations . . . logically limit the patient's autonomous choices to those options the physician can ethically offer."<sup>133</sup> Another policy supporter asserted, "[T]he profession that creates a treatment has innate authority and obligation to prescribe its proper use."<sup>134</sup>

Supporters further argue that unilateral decision-making is defensible because it is not based on individual, subjective

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128. *Id.*

129. Clarke, *supra* note 96, at 762.

130. See Capron, *supra* note 117, at 42.

131. Schneiderman et al., *Medical Futility*, *supra* note 55, at 953.

132. *Id.*

133. See Doty & Walker, *supra* note 103, at II-8.

134. *Id.* See also SUSAN B. RUBIN, WHEN DOCTORS SAY NO: THE BATTLE GROUND OF MEDICAL FUTILITY 61 (Indiana University Press 1998) ("Many physicians are convinced that their clinical judgment entitles them to make not only judgments of factual ineffectiveness from a factual perspective, but also judgments of inappropriateness from an evaluative perspective.").

judgments, but on the standards of the profession.<sup>135</sup>

This power resides not with the individual physician's arbitrary whim but with the profession as a whole as it establishes general standards of care. In our view, abuses of power are resolved not by eliminating medical judgment and yielding to unreasonable demands but rather by exercising judgment openly and responsibly according to professional standards.<sup>136</sup>

However, critics assert that appeals to futility as justification for unilateral decision-making are merely attempts to conceal unwarranted medical paternalism.<sup>137</sup> They contend that decisions regarding "futile" life-sustaining treatment should not be removed from the carefully constructed requirements of the informed consent process.<sup>138</sup> They emphasize that the overwhelming majority of patients and families agree with and consent to the treatment recommendations of their physicians, even when providers recommend the withdrawal of life-sustaining treatment.<sup>139</sup> When conflicts do arise, most can be resolved through extensive and focused negotiation without compromising the patient's autonomy. Therefore, it is difficult to accept the argument that physicians should not be required to seek the consent of the many, merely because they will not be able to secure it from the very few.<sup>140</sup>

Additionally, the lack of a consensus on appropriate end-of-life decision making practices undermines the contention that providers are obligated to adhere to an accepted standard. In other words, it is difficult to agree with the assertion that physicians should be granted the authority act unilaterally because they are complying with professional standards, when

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135. Schneiderman et al., *Response to Critiques*, *supra* note 102, at 670.

136. *Id.*

137. Stuart Younger, *Who Defines Futility*, 260 JAMA 2094, 2095 (1988). See George Smith, *Futility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition Against Cruel and Unusual Punishment*, 12 J. CONTEMP. HEALTH L. POL. 1, 18 (1995-1996).

138. See *id.*

139. See Giles Scofield, *Medical Futility: Can We Talk?* 18 GENERATIONS 66, 67 (Winter 1994) (noting that "the overwhelming majority of patients (94%) agree with their physician's recommendation not to carry out medically futile treatment").

140. *Id.* at 67-68.

the existence of such standards is questionable.<sup>141</sup> Furthermore, even if such standards exist, why should "professional integrity" be weighted more than other ethical obligations, particularly the duty to respect patient autonomy?<sup>142</sup>

The lack of a common understanding as to what constitutes futile treatment is also problematic when futility is used to override the individual's autonomous choices. When considering a life-sustaining treatment, if the intervention is truly futile in a physiologic sense, the issue will quickly become moot because the patient will die. Therefore, conflicts over "futile" life-sustaining treatment exist only when some other ostensibly less objective definition of futility is applied. Allowing health care providers to substitute their subjective assessment of the risks and burdens of treatment for that of a patient should be rejected, because it falsely presumes that "bias, prejudice, and other subjective considerations do not affect physician judgment in this area."<sup>143</sup>

The notion that health care providers possess an innate authority to make decisions without the input of patients and their families is also not well supported. In fact, research has shown that almost all patients prefer that if they become incompetent, decisions regarding life-sustaining medical

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141. Interestingly, when confronted with the notion that the state could override a patient or surrogate decision to refuse life-sustaining care, the American Medical Association emphasized the autonomy of patients, arguing:

Physicians will always strive vigorously to assist those who want help in their struggle against death. Nevertheless, the reality of modern science is that some patients, though permanently unconscious and thus without hope of recovery, can be sustained solely by means of medical treatment and sophisticated technology. For these patients, the ultimate judgment about the proper course of medical care should be made by those most directly affected—the patient or surrogate—and not by the state . . . .

See Brief for the American Medical Association et al., as Amici Curiae Supporting Petitioner, *Cruzan v. Dir. Missouri Dep't Health*, 497 U.S. 261 (1989) (No. 88-1503), 1989 WL 1115247.

142. See generally P. Biegler, *Should Patient Consent Be Required to Write a Do Not Resuscitate Order?* 29 J. MED. ETHICS 359, 361 (2003).

143. *Id.* ("While we might like to believe that judgments about medically futile treatment are value-free, objective, constant, and certain, they are as value-laden, subjective, varied, and uncertain as every other medical judgment is. For this reason, such decisions should be part of, not exempt from, the informed consent process.").

treatment should be made by their family members.<sup>144</sup> Again, critics warn that this presumed authority undermines the autonomy of patients; actions taken under the guise of assumed authority will severely weaken patient trust.<sup>145</sup> The resulting mistrust will only exacerbate, rather than resolve, end-of-life treatment conflicts.<sup>146</sup>

Finally, it is not particularly useful or accurate to characterize futility policies as guidelines that are necessary to contend with unreasonable family members who "demand" ineffective treatment. While data is limited, most futility disputes appear to involve interventions that have been previously offered, recommended, or implemented by health care providers.<sup>147</sup> Assuming providers were not disingenuous in initiating treatment in the first place, at some point the health care providers maintained that the treatment in question was indeed a viable medical option. Disputes over "futile" treatment appear to arise much later, when providers come to believe that the predicted benefit is not achievable or simply not worthwhile. Thus, in many futility disputes it is family members who seek to maintain the status quo, and health care providers who "demand" withdrawal. Considering that weighing the burdens and benefits of treatments is a highly subjective process and that the perspectives of providers and family members differ significantly, it should not be unexpected, or regarded as unreasonable, that family members occasionally reject the calculus of health care providers.

Policy critic Robert Burt has suggested that a provider-family dispute is best understood as a conflict in which the principles of patient autonomy and physician integrity "are essentially in equipoise, without an overarching principle of

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144. Laura Hanson et al., *What is Wrong with End of Life Care? Opinions of Bereaved Family Members*, 45 J. AM. GERIATR. SOC. 1339, 1343 (1997) (finding 90% of patients prefer family members to act as the decision makers and request that decisions be made in conjunction with their physicians).

145. See Mebane et al., *supra* note 21, at 586.

146. *Id.*

147. *Id.* at 67.

resolution."<sup>148</sup> Burt contends that effective dispute resolution can only be achieved through a process of negotiation<sup>149</sup> in which each party to the conflict has "a mutually recognized, independent source of influence and authority to exert against the opposing party."<sup>150</sup> According to Burt, the "basic problem" with policies that permit unilateral decision-making is that such policies do not promote fair negotiation and stand "too ready to serve physicians as a conversation stopper."<sup>151</sup>

### III. LEGAL CONSIDERATIONS

In addition to unanswered ethical concerns, the legality of institutional or statutory futility policies is questionable. When presented with disputes regarding medical treatment, courts have consistently emphasized two important concepts: first, that an adult, competent patient has a constitutionally protected right to determine what shall be done to his or her body;<sup>152</sup> and second, that this right of self-determination extends to

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148. Robert Burt, *The Medical Futility Debate: Patient Choice, Physician Obligation, and End-of-Life Care*, 5 J. PALLIATIVE MED. 249, 253 (2002).

149. *Id.* at 249.

150. *Id.* at 254.

151. *Id.* See also Thomas Prendergast, 283 JAMA 3198, 3200 (2000) (letter to the editor, stating "[f]utility is a conflict resolution strategy based on power, not persuasion").

152. See, e.g., *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250 (1891) (emphasizing the importance of respect for individual autonomy in a case in which the Court concluded a person could not be ordered to submit to a surgical intervention); *Tune v. Walter Reed Army Med. Hosp.*, 602 F. Supp. 1452 (D.C. 1985) (granting a competent patient's request for an order directing the removal of life support because the various state interests were insufficient to outweigh the patient's interest in self-determination); *Deel v. Syracuse Veterans Admin. Med. Ctr.*, 729 F. Supp. 231 (N.D.N.Y. 1990) (holding that an individual has a constitutional right, whether recognized as a liberty interest protected by the Due Process Clause, or an aspect of the right to privacy, to refuse or discontinue life-sustaining medical treatment); *In re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1976) (recognizing a constitutionally protected right of privacy that includes the right to direct the withdrawal of life-sustaining treatment); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 224 (Cal. Ct. App. 1984) (holding that a competent adult patient has the right to direct the withdrawal of treatment, even if it is contrary to physician recommendations.); *Bouvia v. Super. Ct. of Los Angeles County*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986) (holding that competent patient's right to refuse medical treatment entitled her to removal of a feeding tube despite the life-sustaining nature of the treatment); *Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990) (holding that the right to refuse treatment is based in both common and constitutional law).

incompetent patients through surrogate decision makers.<sup>153</sup> The right of self-determination is an aspect of personal liberty that is carefully guarded by a combination of common law and constitutional guarantees, and it cannot be restricted or infringed without due process of law. Futility policies that allow providers to substitute their judgment for that of a competent patient or a duly appointed surrogate violate the common law principle of self-determination and constitutional guarantees of procedural due process.<sup>154</sup>

### *THE RIGHT OF SELF-DETERMINATION*

The right to make fundamental medical decisions is an aspect of self-determination that is jealously guarded by common law and constitutional guarantees.<sup>155</sup> This common law principle has evolved into the widely accepted doctrine of informed consent, which requires that a competent adult be provided with sufficient information and the opportunity to make her own personal medical decisions without the

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153. See, e.g., *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988) (holding that an incompetent patient had a constitutional right to privacy, which included the right to refuse life-sustaining medical treatment, that could be exercised by the patient's guardian.); *In re Storar*, 420 N.E.2d 64, 70-73 (N.Y. 1981) *cert. denied*, 454 U.S. 858 (1981) (affirming an order to withdraw a ventilator from an incompetent patient because the withdrawal was consistent with the patient's repeated, stated wishes while competent); *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987) (holding that a guardian had the right to exercise an incapacitated patient's right to refuse medical treatment). See also *Conservatorship of Drabick*, 245 Cal. Rptr. 840, 852 (Ct. App. 1988); *Mack v. Mack*, 618 A.2d 744, 756 (Md. 1993); *In re Fiori*, 673 A.2d 905, 910 (Pa. 1996); *In re Tavel*, 661 A.2d 1061, 1068 (Del. 1995).

154. In addition such policies may violate constitutional guarantees of privacy, freedom of religion, and the prohibition of cruel and unusual punishment, and to the extent that such policies allow providers to override the documented treatment preferences of a competent adult, such policies may conflict with state advance directive laws.

155. See *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (invalidating the sterilization of habitual criminals on equal protection grounds); *Griswold v. Connecticut*, 381 U.S. 479, 480 (1965) (concluding that a statute which prohibited a person from using contraception violated a federal right of privacy); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (recognizing an unmarried couple's right of privacy in decisions concerning contraception). While the majority of courts that have addressed this right have done so in the context of the individual's right to refuse medical treatment, the principles explicated in these discussions are instructive.

interference of others.<sup>156</sup>

The doctrine of informed consent emphasizes the primacy of the individual in making personal medical treatment decisions. In *Cobbs v. Grant*, the California Supreme Court concluded that the role of health care providers in the informed consent process is necessarily restricted, asserting that the expertise and authority of health care providers extends only to advising the patient and providing sufficient information regarding the risks and benefits of various treatment alternatives.<sup>157</sup> Weighing the risks and benefits of treatment is a subjective process that is beyond the scope of the physician's expertise, a "non-medical judgment reserved to the patient alone."<sup>158</sup>

In addition to common law principles, courts have consistently emphasized that an individual's right to make personal decisions is protected by both federal and state constitutional guarantees. Courts have found that the right of self-determination emanates from a number of constitutional sources. For example, some courts have characterized the right to make personal medical decisions as an aspect of a constitutionally protected right to privacy,<sup>159</sup> while other courts

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156. See F. ROZOVSKY, CONSENT TO TREATMENT, A PRACTICAL GUIDE, 1-98 (2d ed. 1990).

157. *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (Cal. 1972).

158. *Id.* at 243. See, e.g., *In re Conroy*, 486 A.2d 1209, 1225 (N.J. 1985) (informed consent only has meaning if it is respected even when it conflicts with doctor's advice or values of the medical profession); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225 (1984) (patient's rights must be "paramount to the interests of the patient's hospital and doctors"); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 427 (1977) (if a patient's right to refuse treatment is founded in "the right to bodily integrity . . . and control of one's own fate, then [it is] superior to the institutional considerations"). See also *Bouvia v. Super. Ct. of Los Angeles County*, 225 Cal. Rptr. 297, 305 (1986) (emphatically denying that the interests of the medical profession limit the patient's right to refuse treatment: "Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. . . . It is not a conditional right subject to approval by ethics committees or courts of law.").

159. E.g., *Superintendent of Belchertown State Sch.*, 370 N.E.2d 417, 426-427; see also *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225 (1984) (patient's right to refuse treatment "has its origins in the constitutional right of privacy"); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (addressing the right to refuse based solely on privacy). The right of privacy has been found by the court to be implicit in the concept of liberty guaranteed by § 1 of the Fourteenth Amendment. *Roe v. Wade* (1973) 410 U.S. 113,



have held that when an individual chooses a course of treatment based on religious convictions, the individual's right to privacy overlaps with the right to freely exercise personal religious beliefs.<sup>160</sup>

Other courts have held that the right of self-determination flows from a combination of common law and constitutional sources. For example, according to the Wisconsin Supreme Court, the right to make fundamental medical decisions "emanates from the common law right of self-determination and informed consent, the personal liberties protected by the Fourteenth Amendment, and from the guarantee of liberty in Article I, section I of the Wisconsin Constitution."<sup>161</sup> In *Fosmire v. Nicoleau*, the Court of Appeals of New York asserted that the common law right of a competent adult to determine the course of his or her own medical treatment is coextensive with a liberty interest that is protected by the due process clause of the New York Constitution.<sup>162</sup>

Regardless of the source, state and federal courts have uniformly held that an individual's fundamental interest in making medical treatment decisions is not lost upon a finding that the patient lacks the capacity to communicate his or her own choices.<sup>163</sup> According to the Seventh Circuit Court of Appeals, "a patient's incompetency should not deprive him of a liberty interest in 'making' treatment decisions. Such a rule would have the absurd result of granting less protection to those

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*reh'g denied*, 410 U.S. 959 (1973); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49 (1973), *reh'g denied*, 414 U.S. 881 (1973), and on remand, 201 S.E.2d 456 (1973), *cert denied*, 418 U.S. 939 (1974), *reh'g denied*, 419 U.S. 887 (1974).

160. See *Wons v. Public Health Trust*, 500 So. 2d 679, 686-87 (Fla. 3d D.C.A. 1987) ("Running through all of these decisions, however, is the courts' deeply imbedded belief, rooted in our constitutional traditions, that an individual has a fundamental right to be left alone so that he is free to lead his private life according to his own beliefs free from unreasonable governmental interference. Surely nothing, in the last analysis, is more private or more sacred than one's religion or view of life, and here the courts, quite properly, have given great deference to the individual's right to make decisions vitally affecting his private life according to his own conscience. It is difficult to overstate this right because it is, without exaggeration, the very bedrock on which this country was founded.").

161. *Guardianship of L.W.*, 482 N.W.2d 60, 65 (Wis. 1992).

162. *Fosmire v. Nicoleau*, 551 N.E.2d 77, 80-81 (N.Y. 1990).

163. See *Guardianship of L.W.*, 482 N.W.2d 60.

incompetent patients who are in greater need of it.”<sup>164</sup>

In an effort to extend constitutional protections to incapacitated patients, courts have consistently concluded that if a patient clearly communicated his or her preferences prior to becoming incapacitated, those preferences should be honored.<sup>165</sup> In the absence of a clear statement by the patient, the patient’s spouse or another close family member is asked to recommend the course of treatment that the patient himself would choose to pursue based upon their intimate knowledge of the patient’s beliefs. Generally, family members are allowed to render their best judgment, subject to certain qualifications and standards of proof.<sup>166</sup> The surrogate decision-making standards adopted by courts reflect the commonly held belief that the preservation of an incapacitated patient’s right of self-determination requires an intimate understanding the patient’s personal values.

## PROCEDURAL DUE PROCESS

Under the Fifth and Fourteenth Amendments to the U.S. Constitution, neither the federal, nor state governments shall deprive any person of “life, liberty, or property without due process of law.”<sup>167</sup> The basic function of the due process clause is to promote fairness and justice by ensuring that any restriction or infringement on an individual’s interest in life, liberty, or property is preceded by certain procedures. To determine whether a statute such as the Texas Advance Directive Act meets procedural due process requirements, the court employs a two-step analysis.<sup>168</sup>

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164. *Lojuk v. Quandt*, 706 F.2d 1456, 1466 (7th Cir. 1983). Wisconsin has joined this consensus. See *Guardianship of L.W.*, 482 N.W.2d at 67.

165. See, e.g., *Guardianship of L.W.*, 482 N.W.2d 60.

166. See, e.g., *Matter of Quinlan*, 355 A.2d 647.

167. U.S. CONST. amends. V & XIV. Under the doctrine of procedural due process, “the deprivation by state action of a constitutionally protected interest in ‘life, liberty, or property’ is not in itself unconstitutional; what is unconstitutional is the deprivation of such an interest without due process of law.” *Casteel v. McCaughtry*, 176 Wis. 2d 571, 579, 500 N.W.2d 277 (1993). Most state constitutions contain parallel provisions guaranteeing due process for their citizens.

168. *Jones*, 165 U.S. 180.

First, the court must determine whether there is a constitutionally protected interest at issue.<sup>169</sup> Undoubtedly, the right to make fundamental medical decisions, an essential aspect of self-determination, is a protected liberty interest. Courts have repeatedly recognized that decisions such as these are of such personal import that the ability to make them without the interference of others is essential to the concept of liberty.<sup>170</sup> According to the U.S. Supreme Court:

While this court has not attempted to define with exactness the liberty thus guaranteed. . . . Without doubt, it denotes not merely freedom from bodily restraint but also the right of the individual . . . to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men.<sup>171</sup>

Because weighing the benefits and burdens of medical treatment is a deeply personal process, particularly when the treatment is life-sustaining, the ability to do so without the inference of others is essential to concept of individual liberty. According to the United States Supreme Court, "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."<sup>172</sup> Thus, just as the due process clause protects an interest in refusing life-sustaining medical treatment, it protects an individual's right to decide whether to accept or continue such treatment.<sup>173</sup>

In addition, a court must consider the individuals' fundamental interest in life itself. A decision to withhold or

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169. *Id.*

170. *See* *Lawrence v. Texas*, 539 U.S. 558, 574 (2003). Protected personal decisions have included the right to marry. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

171. *Id.*

172. *See Lawrence*, 539 U.S. at 574 (citation omitted).

173. The United States Supreme Court has concluded that the individual's right to direct the course of his own medical treatment is "properly analyzed in terms of a Fourteenth Amendment liberty interest." *Cruzan v. Dir. of Missouri Dept. of Health*, 497 U.S. 261, 279 (1990) (citation omitted).

withdraw life-sustaining treatment will result in the death of the patient and may have profound and lasting effects on family members and other interested parties.<sup>174</sup> In *Cruzan v. Director, Missouri Department of Health*,<sup>175</sup> a seminal end-of-life decision-making case, the U.S. Supreme Court asserted, “[i]t cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.”<sup>176</sup>

Once the court identifies a protected interest, the next step of procedural due process analysis requires the court to consider whether the procedures attendant to the deprivation or encumbering of the identified interest provide sufficient protection from error or abuse.<sup>177</sup> Basic procedural requirements include proper notice,<sup>178</sup> the opportunity for a meaningful hearing,<sup>179</sup> and access to an impartial decision-maker.<sup>180</sup> The U.S. Supreme Court has articulated a balancing test to identify the necessary procedures.<sup>181</sup> Generally, the court must consider three distinct factors: (1) the importance of the private interest that will be affected; (2) the risk of error under current procedures and the extent to which additional or substitute procedures can increase the accuracy of decision-making, and (3) the burdens that will result from requiring new or additional procedures.<sup>182</sup>

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174. While the withdrawal itself is done by private actors, when it is done pursuant to statutory guidelines a court is likely to conclude it is state action.

175. 497 U.S. 261 (1990).

176. *Id.* at 281.

177. *Jones*, 165 U.S. 180.

178. *See Cleveland Bd. of Ed. v. Loudermill*, 470 U.S. 532, 542 (1985) (“An essential principle of due process is that a deprivation of life, liberty, or property ‘be preceded by notice and opportunity for hearing appropriate to the nature of the case.’”).

179. *Id.*

180. *Gibson v. Berryhill*, 411 U.S. 564 (1973).

181. *See Matthews v. Eldridge*, 424 U.S. 319, 336 (1976).

182. *Id.*

*PRIVATE INTERESTS AND RISKS OF ERROR*

As discussed, disputes regarding "futile" life-sustaining medical treatment implicate the patient's fundamental interests in life and liberty. The need for effective protection of these critical interests cannot be understated; any interference with these private interests by health care providers must be preceded by substantial procedural protections.

The potential for error and the inability to remedy such an error is also an important concern.<sup>183</sup> Courts confronted with end-of-life treatment disputes have consistently emphasized that states have an interest in preserving and protecting the lives of their citizens from erroneous decisions or abuse.<sup>184</sup> For example, in *Cruzan v. Director, Missouri Department of Health*,<sup>185</sup> the United States Supreme Court emphasized the serious nature of life-sustaining treatment decisions.<sup>186</sup> The Court noted that "an erroneous decision to withdraw such treatment is not susceptible of correction," and found that a state has a legitimate interest in protecting its citizens from decisions made in error.<sup>187</sup> Many state courts have echoed the concerns expressed by the *Cruzan* court.<sup>188</sup>

In addition to decisions made in error, courts have expressed concern about the potential for abuse and have stressed the state's duty to protect vulnerable populations. Citing Barry R. Furrow, the Wisconsin Supreme Court warned:

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183. *Cruzan*, 497 U.S. 261.

184. See, e.g., *Cruzan v. Director, Missouri Dept. Health*, 497 U.S. at 281; *Matter of M.F.*, 563 N.W.2d 485, 490 (1997) ("The reason this court requires a clear statement of the ward's desires is because of the interest of the state in preserving human life and the irreversible nature of the decision to withdraw nutrition from a person."); *Conservatorship of Wendland*, 28 P.3d 151, 170 (Cal. 2001) (stating that an erroneous decision on the part of a conservator "would represent the gravest possible affront to a conservatee's state constitutional right to privacy" and concluding that "[t]he role of a high evidentiary standard in such a case is to adjust the risk of error to favor the less perilous result.").

185. 497 U.S. 261 (1990).

186. *Id.* at 281. ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality.").

187. *Id.* These interests have been echoed in numerous other cases involving disputes over life-sustaining treatment.

188. See *Conservatorship of Wendland*, 28 P.3d at 547.

While at first euthanasia may be institutionalized only for those in terrible pain, or those who are terminally ill, or those for whom it is otherwise appropriate, the pressure of the allocation of health care resources will inevitably enlarge the class for whom euthanasia is deemed appropriate. Every society has a group who are deemed to be socially unworthy and members of that group—the uneducated, the unemployed, the disabled, for example—will become good candidates for euthanasia.<sup>189</sup>

Policy supporters argue that the processes established in the Texas statute provide sufficient protection from error and abuse. The linchpins of this assertion are threefold (1) the ability of providers to consistently and objectively identify “inappropriate” treatment, (2) the reliability of ethics or medical committee review, and (3) the potential ability to transfer the patient to another facility. However, none of these mechanisms adequately prevent the statute from being arbitrarily or capriciously applied, nor should they be considered sufficient to ensure the protection of vulnerable populations.

The first problem with the assertion that the Texas statute provides adequate protection against error and abuse is that the statute is unacceptably overbroad and vague with regard to the identification of “inappropriate” treatment. When treatment can or should be described as “inappropriate” is not defined by the statute. Certainly, if there is no professional consensus on how to identify “futile” medical treatment, there is even less agreement about what constitutes “inappropriate” treatment. Although policy supporters have argued that the lack of a precise definition is not problematic because “most physicians now know it when they see it,”<sup>190</sup> it is indeed troublesome that the public will not see it when they know it. This lack of

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189. Barry R. Furrow et al., *BIOETHICS: HEALTH CARE LAW AND ETHICS* 325 (1991), as cited in *Matter of M.F.*, 563 N.W.2d 485, 490. See also *Washington v. Glucksberg*, 521 U.S. 702, 706 (1997) (emphasizing the state’s interest in “protecting the poor, the elderly, disabled persons, the terminally ill, and persons in other vulnerable groups from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards voluntary and perhaps even involuntary euthanasia.”).

190. See Robert Fine & Thomas Mayo, *Advance Directive, Due Process, and Medical Futility*, 140 *ANNALS INTERN. MEDICINE* 404, 404 (2004).

boundaries and oversight allows the providers far too much discretion.

The second problem is that although the basic requirement of notice appears to be met, the Texas statute does not provide for a meaningful hearing. A basic requirement of due process is the opportunity to be heard.<sup>191</sup> Such a hearing must be "at a meaningful time and in a meaningful manner," and it must provide interested persons with an effective opportunity to communicate their position by confronting opposing opinions and presenting their own arguments.<sup>192</sup> Under the Texas statute, the physician's decision to withhold or withdraw treatment must be reviewed by a medical or ethics committee.<sup>193</sup> Although providers or the committee *may* provide the patient or family members a written description of the ethics or medical committee review process, they are not required to do so.<sup>194</sup> In addition, while providers must allow the patient or family members to be present at committee deliberations, the extent of their involvement or participation in the discussion is left to the discretion of providers.<sup>195</sup>

Thus, the statute does not ensure that the patient or family members will have an adequate opportunity to present their concerns. In addition, considering the wide disparity in expertise and authority that exists between health care providers and patients and their families, the representation of counsel and an adversarial proceeding may be necessary to ensure fairness. According to the *Cruzan* court, "[a]n adversarial proceeding is of particular importance when one side has a strong personal interest which needs to be counterbalanced to assure the court that the questions will be fully explored."<sup>196</sup> It is notable that courts have traditionally favored a less formalized process for

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191. *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970).

192. *Id.*

193. TEX. HEALTH & SAFETY CODE ANN. § 166.046(b)(1) (Westlaw through 2005 legislation).

194. *Id.*

195. TEX. HEALTH & SAFETY CODE ANN. §166.046(b)(4)(a) (Westlaw through 2005 legislation).

196. *Cruzan*, 497 U.S. at 318.

end-of-life decision-making, holding that that judicial intervention and approval is unnecessary when a surrogate seeks to make treatment decisions that are consistent with the recommendations of health care providers and the patient's prior express wishes.<sup>197</sup> However, when significant questions or disagreements arise, courts have emphasized the importance of prior judicial authorization.<sup>198</sup>

Third, while ethics or medical committees can provide meaningful input and invaluable assistance in resolving disputes,<sup>199</sup> committee recommendations should not be regarded as the findings of an impartial tribunal. Committee members are often employees or administrators of the institution that is providing the patient's treatment. Because the institution may have a significant financial interest in the discontinuation of treatment, financial and other political, hierarchical and institutional pressures may unduly influence committee members and create substantial conflicts of interest.<sup>200</sup> At least one court has questioned whether an institutional ethics committee that offered recommendations in an end-of-life decision-making dispute properly understood its purpose.<sup>201</sup>

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197. See, e.g., *Guardianship of Browning*, 568 So. 2d 4, 15 (Fla. 1990). This applies whether the patient has communicated his or her desires in oral declarations or through written advance directives. *Rasmussen*, 741 P.2d at 691; *Guardianship of Hamlin*, 689 P.2d 1372, 1378 (1984) ("[I]f the treating physicians, the prognosis committee, and the guardian are all in agreement that the incompetent patient's best interests are served by termination of life sustaining treatment . . . there is no need for judicial involvement in this decision."); *Matter of Colyer*, 660 P.2d 738, 746 (Wash. 1983) ("In cases where physicians agree on the prognosis and a close family member uses his best judgment as a guardian to exercise the rights of the incompetent, intervention by the courts would be little more than a formality."); *Barber v. Super. Ct. of Los Angeles County*, 195 Cal.Rptr. 484, 493 (Cal. Ct. App. 1983).

198. See, e.g., *Matter of Peter*, 529 A.2d 419, 427 (N.J. 1987) ("[W]here the Ombudsman determines that a patient . . . has left clear and convincing evidence that he or she would not want to be sustained by life-support, judicial review of a surrogate's decision to give effect to the patient's preference is unnecessary unless a conflict arises among the surrogate decisionmaker, the family, the physician and the Ombudsman."); *Guardianship of Browning*, 568 So. 2d at 4.

199. See Lawrence Schneiderman et al., *Effects of Ethics Consultations on Nonbeneficial Life Sustaining Treatment in the Intensive Care Setting*, 290 JAMA 1166, 1166 (2003).

200. At a minimum, committee review should come from outside the institution that is treating the patient.

201. *Matter of M.F.*, 563 N.W.2d at 485. For a discussion of the role of ethics committees, see Gregory A. Jaffe, *Institutional Ethics Committees: Legitimate and Impartial*



Policy critics have also noted there are no widely accepted standards for committee membership, training, or decision-making processes,<sup>202</sup> and have discouraged over-reliance on ethics committee findings, asserting that committee processes often lack reliability,<sup>203</sup> consistency,<sup>204</sup> transparency,<sup>205</sup> accountability,<sup>206</sup> and reviewability.<sup>207</sup>

Finally, the ability to transfer the patient to another setting is also an ineffective protective mechanism. Transferring a seriously ill patient who is dependent on expensive technology is inevitably complicated by economics. A potential receiving institution may decline to accept a patient, not because of a determination that the treatment the patient seeks is inappropriate, but because the treatment in question is costly.<sup>208</sup>

Considering all of the above, it appears there is a substantial and worrisome risk that the Texas statute will result in error or

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Review of Ethical Health Care Decisions, 10 J. LEGAL MEDICINE 393 (1989).

202. John C. Fletcher & Diane E. Hoffmann, *Time to Experiment with Standards*, 120 ANNALS INTERN. MED. 335, 335-338 (1994) ("[I]t is widely recognized that there is a significant lack of data on the effectiveness of these committees and that committee members often lack the requisite education and skills for effective participation in case consultation. We argue that before granting ethics committees additional authority, there is a need for more research on their performance and a period of experimentation with quality standards governing their membership and operations." Janet Fleetwood and Stephanie S. Unger, *Institutional Ethics Committees and the Shield of Immunity*, 120 ANNALS INTERN. MED., 320, 321 (1994) ("the appropriate authority of ethics committees must be questioned in light of the considerable variability among the composition of committees, the qualifications of committee members, their familiarity with ethical concepts, and their interpersonal skills").

203. Fleetwood and Unger, *supra* note 202, at 322 ("Although long-standing discussion has occurred there is scant research showing the soundness of recommendations from ethics committees.").

204. *Id.* at 323.

205. *Id.* at 322 ("The judicial process is scrutinized by the media and the public, whereas ethics committee proceedings rarely receive the same public analysis.").

206. *Id.* ("[M]any ethics committees lack uniform procedural guidelines, a consistent policy of notifying all involved parties that a committee discussion will occur, or an appeal process.").

207. *Id.* ("[U]nresolved concerns exist about the confidentiality and discoverability of ethics committee proceedings, despite admonitions about the importance of committee accountability, equitable access to committee services, clear documentation of recommendations, and mechanisms for peer review.").

208. See Hopper, *supra* note 5 (reporting that the chief medical officer of a local hospital stated "[a] patient's inability to pay for medical care combined with a prognosis that renders further care futile are two reasons a hospital might suggest cutting off life support.").

abuse. However, the analysis under this prong also requires the court to determine whether new or additional procedures will decrease the potential risk. Clearly, expanding the applicable procedural requirements, including providing guidelines for the decisions made by health care providers, allowing for a meaningful hearing, and establishing review by an impartial tribunal will significantly reduce the risk of error and abuse.

### **BURDENS OF NEW AND ADDITIONAL PROCEDURES**

Finally, a court must consider the burden of new or additional procedures. Considering the infrequency with which futility disputes arise, requiring judicial review and authorization does not appear to be unduly burdensome for courts. At present, intractable conflicts between patients, families, and providers regarding "futile" end-of-life treatment are somewhat rare,<sup>209</sup> and most can be resolved through extensive negotiation between the parties. In order provide the necessary procedural protections, a court need not necessarily create "new" procedures. In an effort to promote and protect the vital interests of patients who lack decision-making capacity, courts have already adopted relatively consistent surrogate decision-making standards that apply when someone other than the patient herself makes medical treatment decisions.<sup>210</sup> Courts

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209. In the vast majority of such disputes patients, family members, and providers are able to achieve consensus on the desired course of treatment after careful discussion. In addition, most end-of-life treatment conflicts do not involve patients or families who seek to continue futile treatment, but rather result from situations in which providers' seek to continue aggressive treatment despite patient or family preferences to pursue less aggressive care. See Breen et al., *supra* note 28, at 286. In the 2001 study, 76% of the provider-family conflicts identified involved cases in which the staff wanted a more aggressive approach; 24% involved cases in which the family wanted to continue aggressive treatment. *Id.* See also Asch et al., *supra* note 13, at 288 (reporting that 34% of ICU physicians surveyed reported that they had continued life-sustaining treatment over the objections of patients and family members.); Joan Teno et al., *Medical Care Inconsistent With Patients' Treatment Goals: Association With 1-year Medicare Resource Use and Survival*, 50J. AM. GERIATR. SOC. 496, 496 (2002) (finding "86% of the patients who wanted aggressive treatment reported that care was consistent with their preferences, but only 41% of those who preferred comfort care reported that care was consistent with their preferences. More than one-third of those with a preference for comfort care (35%) reported that the medical care that they received was inconsistent with their goals.") *Id.* at 496.

210. See, e.g., *Matter of M.F.*, 563 N.W.2d 485, 591 (1997).

have also approved the withholding or withdrawal of life-sustaining treatment despite family objections, but *only* when the court was satisfied that certain evidentiary and procedural requirements were met.<sup>211</sup> Furthermore, the burden of additional procedural requirements would fall most heavily, and appropriately, on the party that seeks to direct the withholding or withdrawal of treatment.

A careful analysis of all of the above factors indicates that the individual patient's constitutionally protected rights to life and liberty are not adequately protected by the procedural mechanisms established under the Texas Advances Directive Act and there is a significant risk that the Texas statute will be unfairly and arbitrarily applied. The consequence of an erroneous or capricious decision will be the death of the patient, thus additional procedural protections are necessary to ensure fairness and justice.

## CONCLUSION

Institutional and statutory medical futility policies are intended to provide a mechanism for the resolution of disagreements in which patients or family members seek treatment that health care providers do not consider worthwhile. However, despite the lack of consensus regarding best practices at end-of-life, disagreement about an acceptable, practical definition of futile treatment, and continued debate about the ethical justification of unilateral decision-making, some institutions and states have adopted policies that permit physicians to withhold or withdraw life-support without the consent of patients or family members. In addition to these concerns, there is a troubling lack of information regarding the prevalence, content, and use of medical futility policies. Critics have warned that such policies significantly undermine the trust that is essential to the physician-patient relationship and may exacerbate, rather than

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211. See, e.g., *In re K*, 735 A.2d 448 (D.C. App. 1999); *In re Tabatha R.*, 564 N.W.2d 598 (Neb. 1997). Most often this occurs when courts are confronted with abusive or neglectful family members.

assist, in resolving conflicts over end-of-life treatment.

The legality of institutional and statutory medical futility policies is also questionable. Because institutional futility policies and statutes such as the Texas Advance Directive Act allow providers to substitute their subjective opinions for those of patients or family members without providing substantial or effective procedural protections, such policies violate the common law principle of self-determination and constitutional guarantees of procedural due process. Although policy supporters contend that health care providers should be able to withhold or withdraw futile treatment because they “know it when they see it,” the protection of individual rights demands that the public see it when they know it. In order to ensure fairness, consistency, and legitimacy in the management of conflicts over life-sustaining medical treatment, the substantial ethical and legal issues surrounding medical futility policies must be actively and thoroughly addressed in a public forum.

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